



Republic of the Philippines
Department of Education
Region VI – Western Visayas
SCHOOLS DIVISION OF CAPIZ

30 APR 2026

DIVISION MEMORANDUM
NO. **177** s. 2026

ANNUAL PHYSICAL EXAMINATION OF TEACHING AND NON-TEACHING PERSONNEL

To: Assistant Schools Division Superintendent
OIC-Chief Education Supervisors
Public Schools District Supervisors
Education Program Supervisors
Heads of Public Elementary, Secondary & Integrated Schools
All Others Concerned

1. Pursuant to Civil Service Commission Memorandum Circular No. 33, s. 1997 (Policy on Working Conditions in the Workplace), DepEd Order No. 14, s. 2020 (Guidelines on the Required Health Standards in Basic Education Offices and Schools), and DepEd Memorandum No. 22, s. 2015 titled “*Annual Physical Examination of DepEd Employees (Teaching and Non-Teaching Personnel)*”, DepEd teaching and non-teaching personnel are hereby requested to undergo voluntary annual physical examination.
2. In line with this, this Office will conduct the Annual Physical Examination for all willing teaching and non-teaching personnel with or without laboratory results from **May 4, 2026 to June 5, 2026**.
3. This activity aims to ensure that personnel are physically fit to effectively perform their assigned roles and responsibilities, thereby delivering quality, healthy, and safe services as public servants.
4. Attached are enclosure No.1 “Schedule of Annual Physical Examination Per District” and the annual physical examination forms for your reference and can be accessed through this link <https://tinyurl.com/SHNUforms2026>
5. Travel expenses relative to the conduct of this activity are chargeable against Division MOOE subject to the usual auditing rules and regulations.
6. For any questions/clarification, you may contact Dionirose L. Duron, MD, Medical Officer III at mobile number 09171186511.
7. Immediate dissemination and compliance of this Memorandum are desired.


ROEL F. BERMEJO
Schools Division Superintendent

Encl: As stated
Reference: As stated
To be indicated in the Perpetual Index
under the following subjects:
Annual Physical Examination



Address: Banica, Roxas City
Contact Number: (036) 620 2371
Email Address: capiz@deped.gov.ph
Website: <http://depedcapiz.ph>



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Enclosure No. 1 to Division Memorandum No. **177**, s. 2026

Schedule of Annual Physical Examination Per District

District	Schedule
Ivisan	May 6, 2026 – Morning
Sapian	May 6, 2026 - Afternoon
Sigma	May 7, 2026
Panay	May 11, 2026
Mambusao East	May 12, 2026
Mambusao West	May 13, 2026
Jamindan	May 14, 2026
Tapaz East	May 18, 2026
Tapaz West	May 19, 2026
Dao	May 20, 2026
Panitan	May 21, 2026
Pres. Roxas	May 25, 2026
Maayon	May 26, 2026
Pontevedra	May 28, 2026
Pilar	June 1, 2026
Dumalag	June 2, 2026
Dumarao	June 3, 2026
Cuartero	June 4, 2026

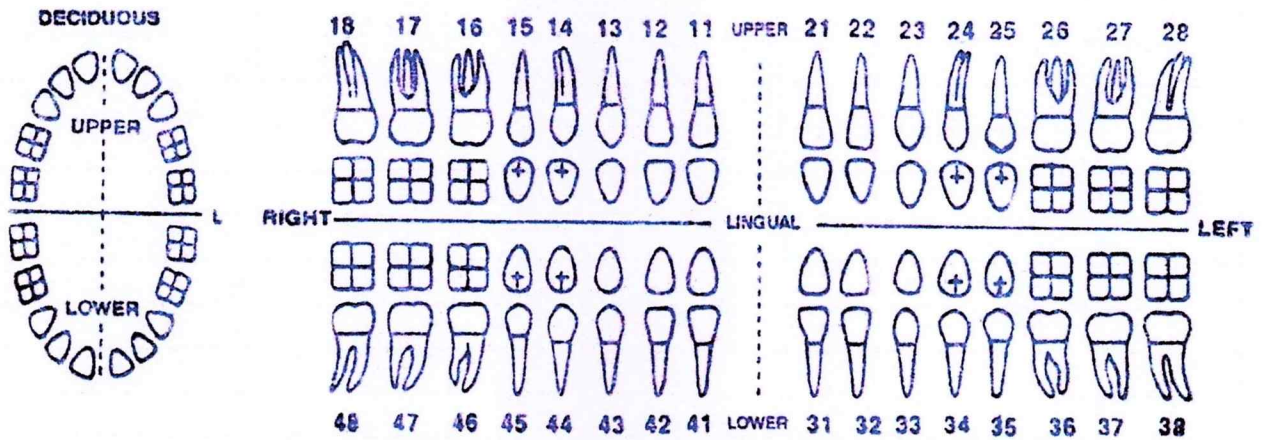


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Name: _____ Age: _____ Sex: _____				
Prefix	Last Name	First Name	Middle Name	Suffix
Address: _____				
No.	Street	Barangay	City/Municipality	Province
Birth date:	Birth place:	Blood type:	Religion:	Nationality: _____ Indigenous Group: Yes No
Civil Status: <input type="checkbox"/> Co-habitation <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Separated <input type="checkbox"/> Annulled	Educ. Attainment: <input type="checkbox"/> Elem <input type="checkbox"/> H.S <input type="checkbox"/> College <input type="checkbox"/> Post Grad <input type="checkbox"/> Vocational <input type="checkbox"/> No form of Educ. <input type="checkbox"/> Not applicable	Employment Status: <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed Nature of work: _____		
Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Passive Smoker	How long? _____	Willing to Stop? <input type="checkbox"/> Yes <input type="checkbox"/> No	Stopped: <input type="checkbox"/> > a year <input type="checkbox"/> < a year	
Alcohol Intake: <input type="checkbox"/> Never Consumed <input type="checkbox"/> Yes, Drinks Alcohol	Excessive intake in the past month: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physical Activity: Does at least 2 1/2 hours a week of moderate-intensity physical activity <input type="checkbox"/> Yes <input type="checkbox"/> No				
Family History: Does patient have 1 st degree relative with: <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart attack <input type="checkbox"/> Kidney stone <input type="checkbox"/> Diabetes				
Mother's first Name	Middle Name	Last Name	Birthdate	
- CONSENT FOR PARTICIPATION TO PHIE				
1. I hereby give my full consent and permission to this facility to gather send and transmit pertinent data or information (with appropriate safety measures to protect the privacy and security of my well being, health information and other rights under laws governing data privacy, security and related issuances? until it is revoked by myself or my duly authorized representative.				
2. I am made aware that I can cancel my consent at any time without giving reasons and without concerning any disadvantage for my medical treatment services.				
I Certify that I have been made to understand my rights in language and manner understandable to me by a representative of the facility/health care provider and that the health data or information is true and complete to the best of my knowledge.				
Signed this _____ day of _____, 202__		Time: _____		
_____ Signature Over Printed Name of Patient/Representative Mobile/Landline No.: _____		_____ Signature Over Printed Name of Health Provider		
Pertinent Health Information, Intervention, and Procedures				
O: WT: _____ kg HT _____ cm RR: _____ Temp: _____ Rechecked: _____	S:			
Heart/Pulse Rate: Regular rhythm: <input type="checkbox"/> Yes <input type="checkbox"/> No Normal rate: <input type="checkbox"/> Yes <input type="checkbox"/> No	A:			
BP: _____ / _____ (Rechecked): _____ / _____ BMI: _____ BMI Category: _____ Risk prediction: _____ Waist circumference _____ cm Central adiposity: <input type="checkbox"/> Yes <input type="checkbox"/> No Obesity: <input type="checkbox"/> Yes <input type="checkbox"/> No	P:			
Assessed by: _____ Date: _____ Time: _____				
Dionirose L. Duron, MD. Medical Officer III Lic. No. 0144542				



NAME _____ ADDRESS _____
 PHONE _____ B-DAY _____ AGE _____ REFERRED BY _____
 PHYSICIAN _____ ADDRESS _____ PHONE _____



PRESENT ORAL COMPLAINT _____

MEDICAL HISTORY: _____
 GENERAL HEALTH _____
 HEADACHES _____ SINUS TROUBLE _____
 ALLERGIES _____ FREQ. COLDS _____
 BLEEDING OF GUMS _____ DIABETES _____
 HEART - B.P. _____ SELF-MEDICATION _____
 FAMILY HISTORY _____

CLINICAL EXAMINATION _____

 FACE AND LIPS _____ CHEEKS _____
 TONGUE _____ PALATE _____ OROPHARYNX _____
 GINGIVAE: SPONGY _____ RETRACTED _____ BLEEDING _____
 MISSING TEETH _____ MALOCCLUSION _____
 PREVIOUS DENTAL CARE _____

REMARKS: _____

